IDAHO DEPARTMENT OF HEALTH & WELFARE

Referral/Recommendation for School-Based Health Related Services

Name of Child _____ MID # _____

Dear Doctor/Clinic: _____

Many children enrolled in school have medical, functional/developmental, and/or psychiatric conditions some of which interfere with their ability to receive an appropriate education. When it is identified that a child has such a condition, the school is required by the Individuals with Disabilities Education Act (IDEA) to provide the services that enable the child to participate in an appropriate educational program. School districts use a multi-disciplinary approach to evaluate, review, and develop an appropriate educational program for the child.

The _____ District
requests your recommendation/referral on the above child for the following Medicaid reimbursable evaluations and therapy/service (if indicated). If the referral is for services being provided under an existing Individual Education Plan (IEP), a copy of the evaluation and plan is attached with this request:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Brief description of the reason for the referral:

_____

_____

_____

Feedback will be provided to you including a copy of the, evaluations, IEP, progress reports, and adjustments in the treatment goals if requested. Please note that the school district understands that the recommendation/ referral, is for services provided by the school district only. If the family requests services that are beyond the scope of health related services that are required to be provided by the school district or the district feels the child needs to be referred for other services, the child will be referred back to you for a referral for those specific services by a different provider.

If you have any questions, call _____ at _____

Please return this form with your signature to the school district's attention:

- ☐ One year referral
- ☐ More than one year – Must have a current IEP. Indicate number of years_____
- ☐ I can not give a referral at this time as I have not seen this child. Please contract the family and have then come in for an appointment.
- ☐ In addition to the above, please evaluate this child for:

_____

Primary Care Provider Name: _____

Primary Care Provider Signature: _____

Date: _____

healthy connections